Booklet 5

Vision Service Plan

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of Coverage under Vision Service Plan (VSP)

Here are a few highlights of your vision benefits:

- You can use any eye care provider you wish, but benefits are generally higher (your out-of-pocket expenses are less) if you see a VSP provider
- The plan pays benefits if you see a VSP participating or non-VSP provider (optometrist or ophthalmologist)
- Participating VSP providers automatically file claims for you; if you see a non-VSP provider, you must pay the provider in full at the time of service and then submit a claim to VSP for reimbursement.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and the options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive routine vision services from a VSP provider, you pay a $10 copay to the provider once during any 12-month period.

When you receive services from a non-VSP provider, up to a $10 copay may be deducted from your reimbursement. The plan reimburses you up to the dollar amounts shown in the "Summary Table" on the next page, and any amount you pay in excess of the amounts shown is credited against the $10 copay. For example, if you pay $47 for an eye exam ($7 more than the amount VSP reimburses for a non-VSP provider eye exam), VSP deducts only $3 from your reimbursement for the copay.

You are responsible for expenses not covered by this plan.

See "How the Plan Works" (next section) for more information; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for the coverage.

How the Plan Works

► Summary Table

The table on the following page summarizes covered eye care services and eyewear under this plan and identifies related limits (see "Covered Expenses under VSP" and "Expenses Not Covered" in this booklet for more details).

Vision Service Plan		
Covered Expenses	If you see a VSP provider you pay a $10 copay (once during any 12 month period) and the plan pays ...	If you see a non-VSP provider you pay the bill in full and the plan reimburses you the following amounts, minus a maximum $10 copay* (once during any 12-month period) ...
Exams (once every 12 months)	100%	Up to $40
Lenses (1 pair every 12 months)		
● Single vision	100%	Up to $40
● Bifocal	100%	Up to $60
● Trifocal	100%	Up to $80
● Lenticular	100%	Up to $125
● Progressive	100%	Up to $5 for upgrade to progressives, tints and coatings combined
● Tints	100%	
● Coatings	100%	
Frames (once every 24 months)	Covered up to $130; if you choose a frame that costs more than the VSP allowable amount, you'll receive 20% off your out-of-pocket costs	Up to $45
Contacts (once every 12 months in place of eyeglass lenses and frames)		
● Elective (providers may bill you for contact lenses separately or they may include the lenses, fittings and follow-up fees in a single bill; all of these contact lens fees apply to the $105 maximum paid by the plan)	100% up to $105	Up to $105
● Medically necessary (see "Covered Expenses under VSP" for details)	100%	Up to $210

* Your copay depends on the amount your non-VSP provider charges and the amount VSP pays for the covered expense (see "Cost" in this booklet for details).

► VSP Providers

VSP has an extensive nationwide network of private-practice providers (optometrists and ophthalmologists). To find a participating VSP provider near your home or work, contact VSP (see the Resource Directory booklet).

► Accessing Care

Under this plan, you can use any eye care provider you wish, VSP or non-VSP. However, if you see a VSP provider, you receive higher benefits, claims automatically are filed for you and VSP can guarantee patient satisfaction.

To receive VSP-level benefits:

- Make an appointment with your VSP provider. Be sure to identify yourself as a VSP member and give the employee's Social Security number. The VSP provider notifies you if any services you're requesting are not covered.
- Pay a $10 copay when you meet with the provider (you pay only once during any 12-month period).
- The plan pays 100% for most covered services.

You do not need to file claims. Your provider and VSP handle the rest by verifying your benefits and eligibility for services.

To receive non-VSP-level benefits:
- Make an appointment with any licensed eye care provider. If you want to verify that the care you'll receive is covered, contact VSP (see the Resource Directory booklet).
- Pay the bill in full at the time of service.
- File a claim to VSP for reimbursement.

Covered Expenses under VSP

This section describes expenses covered by your VSP benefits. For information on the level of benefits you receive (for example, related limits) see "Summary Table" in this booklet.

Covered vision expenses include:
- Vision exams – a complete analysis of the eye and related structures to determine the presence of vision problems or abnormalities
- Elective contact lenses
- Frames
- Medically necessary contact lenses when preauthorized by VSP and prescribed by an eye care provider for the visual welfare of the patient due to specific medical conditions such as:
  - Cataract surgery
  - Conditions of anisometropia
  - Extreme visual acuity problems that cannot be corrected with eyeglasses
  - Keratoconus
- Spectacle lenses (progressive multifocal lenses are covered when you see a VSP provider).

VSP providers generally require two to three working days to make lenses, based on the lab and eyewear selected. If you don't have a back-up pair of glasses and would like faster turnaround, your provider may be able to accommodate you, depending on their arrangements with the lab. The cost and arrangements vary by provider; contact your VSP provider for details.

Helpful Hint. Each time you receive contact lenses under the plan, you must wait 12 months before you are eligible for lenses (spectacle or contact) and 24 months before you're eligible for frames. If you are interested in getting both glasses and contacts, purchase the glasses first, then you can replace lenses (either contact lenses or spectacle lenses) each year.

Extra-Cost Items

This plan is designed to pay the cost of visual rather than cosmetic needs. You pay the extra cost for:
- Amounts over the low-vision benefit maximum
- Frames above the plan allowance
- Optional cosmetic services, procedures, and eyewear.

A VSP provider can tell you the additional charges for these items.

Low-Vision Benefit

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for the low-vision benefit. To receive this benefit, you may see either a VSP or non-VSP provider, and you must:
- Obtain authorization from VSP before you receive services
- Pay a copay equal to 25% of the cost of services.

The plan pays 100% (after the copay) for analysis and diagnosis, including a comprehensive exam of visual functions, with a prescription for corrective eyewear or vision aids where indicated. The low-vision benefit maximum is $1,000 (excluding the copay) every two years.

If you see a non-VSP provider, you must pay the provider in full and file a claim with VSP for reimbursement. The benefits will not be more than the amount payable had you seen a VSP provider.

Additional VSP Provider Benefits

► Discount for Extra Frames and Lenses

You may purchase an additional pair of frames and prescription lenses from your VSP provider at a 20% discount. To receive this discount, you must make the additional purchase within 12 months of your initial exam and from the same VSP provider.

► Discount for Prescription Contact Lenses

If you see the same VSP provider for a second exam in a 12-month period, and the purpose is to fit you for prescription contact lenses, you'll receive a 15% discount toward the exam and any follow-up services.

► Discount for Laser Vision Correction

VSP has arranged for plan participants to receive laser vision correction from VSP-approved surgeons and laser centers for a discounted fee. Discounts vary by location, but average 15% to 20%. The laser centers may offer an additional price reduction, where VSP participants receive 5% off the advertised price if less than the usual discounted price.

To obtain laser vision services:
- Call your VSP provider to check if he/she participates in the program or contact VSP to locate a participating provider (see the Resource Directory booklet).
- Schedule a free screening and consultation on the advantages and risks of laser vision correction. Your VSP provider will give preoperative care and make arrangements with the VSP-approved surgeon and laser center. (While the screening and consultation are complimentary, if you have a preoperative exam and do not proceed with the surgery, your VSP provider may charge a discounted exam fee up to $100.)

Post-procedure care is coordinated between your VSP provider (optometrist or ophthalmologist) and your VSP surgeon and laser center.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, VSP does not cover:
- Blended lenses (see definition of this term and progressive lenses in the Glossary booklet)
- Costs that exceed plan allowances
- Exams or eyewear required as a condition of employment
- Extra-cost items, as described in this booklet
- Medical or surgical treatment of the eye (see the appropriate medical plan booklet for information on coverage for these expenses)
- Orthoptics or vision training and any associated supplemental testing
- Oversized lenses (61 mm or larger)
- Plano (non-prescription) lenses
- Replacement of lost or broken lenses and frames, except at normal intervals – once every 12 months for lenses (spectacle or contact) and once every 24 months for frames (if frames are broken as the lenses are being inserted, VSP may cover the cost, depending on the age and condition of the broken frames; contact VSP for details)

- Services or materials provided as a result of workers compensation law or similar legislation, or obtained through or required by any government agency or program
- Two pair of glasses in place of bifocals.

What Happens If

► If You Need Emergency Care

If you need immediate and unexpected vision care (for example, because of a sudden change in your sight) or vision hardware (for example, you break your glasses), you may see either a VSP or non-VSP provider and receive VSP-level benefits up to any applicable limits. For care beyond this initial emergency, you'll need to see a VSP provider to receive VSP-level benefits. (See "Summary Table" in this booklet for details on limits and benefit levels.)

► If You Need Care While Traveling

If you need immediate and unexpected vision care (as described above) while you're traveling, you may see either a VSP or non-VSP provider. Benefits depend on whether you choose a VSP or non-VSP provider and are paid at the level shown in "Summary Table" in this booklet

The VSP network of providers is nationwide. To find one in your immediate area, call VSP at the number in the Resource Directory booklet.

► If Your Family Member Lives Away from Home

Family members who live away from home temporarily or permanently may see a VSP or a non-VSP provider. Benefits depend on whether they choose a VSP or non-VSP provider and are paid at the level shown in the "Summary Table" in this booklet.

Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

Filing a Claim

► What to Do

If you receive care from a VSP provider, the provider submits claims for you. If you receive services from a non-VSP provider, you pay the provider in full, and it's your responsibility to submit a claim form to VSP or have the provider submit one for you. Claim forms are available from VSP (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan).

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► How the Claim is Reviewed

VSP will review your claim and notify you or your provider in writing within the following timeframes:
- Within 72 hours for urgent claims. Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You will be notified of the claim review decision by phone with a written notice to follow.
- Within 15 days for pre-service claims (within 30 days if an extension is filed). Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- Within 24 hours for concurrent claims. Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- Within 30 days for post-service claims (within 60 days if an extension is filed). Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions and then notifies you of the decision within the timeframes listed above.

► If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that VSP reviewed in making the determination.

Appealing Denied Claims

► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, VSP notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling VSP and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal with VSP (see the Resource Directory booklet for contact information).

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

VSP will review the written appeal and notify you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 30 days for pre-service appeals
- Within 30 days for post-service appeals (first and second level appeals)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

If you disagree with the resolution of your claim, you have 60 days after receiving the denial to submit a second level appeal with any further documentation to VSP.

VSP has sole discretionary authority to determine benefit payment under the plans; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addendums to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees.

Decisions of the manager are final and binding. If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Payment of Vision Benefits

The vision benefits offered by this plan are funded by King County, making this a "self-funded" plan. Though Vision Service Plan is responsible for the payment of claims, King County is financially responsible for the cost of those claims.